6.6 Property and Related

The following are Property and Related costs:

(a) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, and amortization of leasehold improvements and capital leases,
(b) interest on capital indebtedness,
(c) real estate leases and rents,
(d) real estate/property taxes,
(e) equipment rental,
(f) fire and casualty insurance,
(g) amortization of mortgage acquisition costs.

6.7 Ancillaries

Ancillary services include, but are not limited to non-legend drugs charged, medical supplies-charged, physical therapy, speech therapy, occupational therapy and, respiratory therapy, including the costs of oxygen. Therapy services should be classified as ancillaries whether or not the provider customarily records separate charges for these services. Overhead costs related to ancillary services and supplies are included in ancillary costs.

7 CALCULATION OF COSTS, LIMITS AND RATE COMPONENTS FOR NURSING FACILITIES

Base year costs, rates, and category limits are calculated pursuant to this section. The Medicaid per diem payment rate for each facility is calculated pursuant to Section 9.

7.1 Calculation of Per Diem Costs

Per diem costs for each cost category, excluding the Nursing Care cost category, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90 percent of the licensed bed capacity during the cost period under review calculated pursuant to subsection 5.7.

7.2 Nursing Care Component

(a) Case-Mix Weights.

(1) There are 44 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

Class No.	RUG	Case-Mix Weight	Description
1	RVC	2.0158	Rehabilitation Very High Intensity C
2	RVB	1.4803	Rehabilitation Very High Intensity B
3	RVA	1.3129	Rehabilitation Very High Intensity A
4	RHD	1.8738	Rehabilitation High Intensity D
5	RHC	1.4959	Rehabilitation High Intensity C
6	RHB	1.3746	Rehabilitation High Intensity B
7	RHA	1.2441	Rehabilitation High Intensity A
8	RMC	1.7503	Rehabilitation Medium Intensity C
9	RMB	1.3120	Rehabilitation Medium Intensity B
10	RMA	1.2336	Rehabilitation Medium Intensity A
11	RLB	1.2371	Rehabilitation Low Intensity B
12	RLA	1.1028	Rehabilitation Low Intensity A
13	SE3	3.7496	Extensive Services 3
14	SE2	2.2493	Extensive Services 2
15	SE1	1.5423	Extensive Services 1
16	SSC	1.4054	Special Care C
17	SSB	1.2600	Special Care B
18	SSA	1.1740	Special Care A
19	CD2	1.2334	Clinically Complex D with Depression
20	CD1	1.2002	Clinically Complex D w/o Depression
21	CC2	1.0846	Clinically Complex C with Depression
22	CC1	1.0246	Clinically Complex C w/o Depression
23	CB2	1.0286	Clinically Complex B with Depression
24	CB1	0.9094	Clinically Complex B w/o Depression
25	CA2	0.8834	Clinically Complex A with Depression
26	CA1	0.7337	Clinically Complex A w/o Depression
27	IB2	0.9275	Impaired Cognition B- 2 NSG Rehab
28	IB1	0.8341	Impaired Cognition B
29	IA2	0.7274	Impaired Cognition A- 2 NSG Rehab
30	IA1	0.6283	Impaired Cognition A
31	BB2	0.9283	Challenging Behavior B - 2 NSG Rehab
32	BB1	0.8195	Challenging Behavior B
33	BA2	0.6560	Challenging Behavior A- 2 NSG Rehab
34	BA1	0.5590	Challenging Behavior A
35	PE2	1.0347	Reduced Physical Functioning E 2
36	PE1	0.9925	Reduced Physical Functioning E 1
37	PD2	0.9723	Reduced Physical Functioning D 2
38	PD1	0.9122	Reduced Physical Functioning D 1
39	PC2	0.8327	Reduced Physical Functioning C 2
40	PC1	0.8156	Reduced Physical Functioning C 1
41	PB2	0.7316	Reduced Physical Functioning B 2

42	PB1	0.6536 Reduced Physical Functioning B 1
43	PA2	0.6279 Reduced Physical Functioning A 2
44	PA1	0.5149 Reduced Physical Functioning A 1

(2) For residents certified by the Division of Licensing and Protection to have Atypically Severe Challenging Behaviors, the case-mix weight shall be 1.843.

(b) Average case-mix score

The Department of Aging and Disabilities' Division of Licensing and Protection shall compute each facility's average case-mix score .

(1) The Division of Licensing and Protection shall periodically, but no less frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

(2) For the Base Year, the Division of Licensing and Protection shall certify the average case-mix score for all residents.

(c) Nursing Care cost per case-mix point.

Each facility's Nursing Care cost per case-mix point will be calculated as follows:

(1) Using each facility's Base Year cost report, the total allowable Nursing Care costs shall be determined in accordance with Subsection 6.2.

(2) Each facility's Standardized Resident Days shall be computed by multiplying total Base Year resident days by that facility's average case-mix score for all residents for the four quarters of the cost reporting period under review.

(3) The per diem nursing care cost per case-mix point shall be computed by dividing total Nursing Care costs by the Base Year Standardized Resident Days for that Base Year.

(d) Limits on Nursing Care rate per case-mix point:

(1) The Division shall array all nursing care facilities' Base Year per diem Nursing Care costs per case-mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(2) The limit on per diem Nursing Care costs per case-mix point shall be the median plus 15 percent.

(3) Each facility's Base Year Nursing Care rate per case-mix point shall be the lesser of the limit in subparagraph (2) or the facility's Nursing Care cost per case-mix point. Once all facilities' reported costs are final, this limit will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors.

7.3 Resident Care Base Year Rate

Resident Care Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, the provider's Base Year total allowable Resident Care costs shall be determined in accordance with Subsection 6.3.

(b) The Base Year per diem allowable Resident Care costs for each facility shall be calculated by dividing the Base Year total allowable Resident Care costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Resident Care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be the median plus five percent.

(e) Each facility's Base Year Resident Care per diem rate shall be the lesser of the limit set in paragraph (d) or the facility's Base Year per diem allowable Resident Care costs. Once all facilities' reported costs are final, this limit will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors.

7.4 Indirect Base Year Rate

Indirect Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, each provider's Base Year total allowable Indirect costs shall be determined in accordance with Subsection 6.4.

(b) The Base Year per diem allowable Indirect costs for each facility shall be calculated by dividing the Base Year total allowable Indirect costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Indirect costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be at the median.

(e) Each provider's Base Year Indirect per diem rate shall be the lesser of the limit in paragraph (d) or the facility's Base Year per diem allowable Indirect costs. Once all facilities' reported costs are final, this limit will not change until nursing home costs are rebased pursuant to 5.6(b), except for annual adjustment by the inflation factors.

7.5 Director of Nursing Base Year Rate

The Director of Nursing Base Year per diem rates shall be computed as follows:

(a) Using each facility's Base Year cost report, total allowable Base Year Director of Nursing costs shall be determined in accordance with Subsection 6.5.

(b) Each facility's Base Year per diem allowable Director of Nursing costs shall be calculated by dividing the Base Year total allowable Director of Nursing costs by total Base Year resident days.

(c) The Director of Nursing per diem rate shall be the facility's Base Year per diem allowable Director of Nursing costs calculated pursuant to this subsection.

7.6 Ancillary Services Rate

(a) There is no common or established practice in the State of Vermont regarding:

(1) items and services considered ancillaries,

(2) charging practices.

(b) All therapy services and therapy supplies shall be considered ancillaries, whether or not the provider customarily records charges for these services and supplies. Therapy services shall not be allowable for Medicaid reimbursement pursuant to this subsection unless the services are provided:

(1) pursuant to a physician's order,

(2) by a licensed therapist or other State certified or registered therapy assistant, or other therapy aides, and

(3) the facility has a denial of payment by the Medicare program for the services provided.

(c) Other items and services shall be considered ancillaries if the following requirements are met:

(1) separate charges are customarily recorded by the provider for all residents using this service;

(2) directly identifiable services are rendered to a specific resident;

(3) items or services are furnished at the direction of a physician because of specific medical needs;

(4) and one of the following:

(i) not reusable - e.g., intravenous fluids or solutions, oxygen (including medications), disposable catheters;

(ii) represents a cost for each preparation, e.g., catheters, colostomy bags, drainage equipment, trays and tubing; or

(iii) complex medical equipment - e.g., ventilators, intermittent positive pressure breathing (IPPB) machines, nebulizers, suction pumps, continuous positive airway pressure (CPAP) devices.

(d) The Ancillary per diem rate shall be computed as follows:

(1) Using each facility's most recently settled annual cost report, Medicaid Ancillary costs shall be determined in accordance with subsection 6.7.

(2) Using each facility's most recently settled cost report, the per diem Ancillary rate shall be calculated by dividing allowable Medicaid Ancillary costs by the number of Medicaid resident days. Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.7 Property and Related Per Diem

The Property and Related per diem rate shall be computed as follows:

(a) Using each facility's most recently settled annual cost report, total allowable Property and Related costs shall be determined in accordance with Subsection 6.6.

(b) Using each facility's most recently settled cost report, the per diem property and related costs shall be calculated by dividing allowable property and related costs by total resident days. Any change to the property and related per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

8 ADJUSTMENTS TO BASE RATES

8.1 Change in Services

The Division, on application by a provider, may make an adjustment to the prospective case-mix rate for additional costs which are directly related to:

(a) the offering of a new institutional health service previously approved under the provisions of 18 V.S.A. §2403. Costs greater than those approved in the Certificate of Need (as adjusted for inflation) will not be considered when calculating such an adjustment,

(b) a change in services or facility not covered under the provisions of 18 V.S.A. §2403, if such a change has previously been approved by the Division, or

(c) with the prior approval of the Division, a reduction in the number of licensed beds.

8.2 Change in Law

The Division may make or a provider may apply for an adjustment to a facility's prospective case-mix rate for additional costs that are a necessary result of complying with changes in applicable federal and state laws, and regulations, or the orders of a State agency that specifically requires an increase in staff or other expenditures.

8.3 Facilities in Receivership

(a) The Division, on application by a receiver appointed pursuant to state or federal law, may make an adjustment to the prospective case-mix rate of a facility in receivership for the reasonable and necessary additional costs to the facility incurred on account of the receivership.

(b) On the termination of the receivership, the Division shall recalculate the prospective case-mix rate to eliminate this adjustment.

8.4 **Efficiency Measures**

The Division, on application by a provider, may make an adjustment to a prospective case-mix rate for additional costs which are directly related to the installation of energy conservation devices or the implementation of other efficiency measures, if they have been previously approved by the Division.

8.5 **Interest Rates**

(a) A provider may apply for an adjustment to the Property and Related rate, or the Division may initiate an adjustment if there are cumulative interest rate increases or decreases of more than one-half of one percentage point because of existing financing agreements with a balloon payment or a refinancing clause that forces a mortgage to be refinanced at a different interest rate, or because of a variable rate of adjustable rate mortgages.

(b) A provider with an interest rate adjustment shall notify the Division of any change in the interest rate within 10 days of its receipt of notice of that change. The Division may rescind all interest rate adjustments of any facility failing to file a timely notification pursuant to this subsection for a period of up to two years.

8.6 **Emergencies and Unforeseeable Circumstances**

(a) The Division, on application by a provider, may make an adjustment to the prospective case-mix rate under emergencies and unforeseeable circumstances, such as damage from fire or flood.

(b) Providers must carry sufficient insurance to address adequately such circumstances.

8.7 **Procedures and Requirements for Rate Adjustments**

(a) Application for a rate adjustment pursuant to this section should be made as follows. Approval of any application for a rate adjustment under this section is at the sole discretion of the Director.

(b) Except for applications made pursuant to subsection 4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

(c) Application for a Rate Adjustment shall be made on a form prescribed by the Director and filed with the Division and shall be accompanied by all documents and proofs determined necessary for the Division to make a decision.

(d) The burden of proof is at all times on the provider to show that the costs for which the adjustment has been requested are reasonable, necessary and related to resident care.

(e) The Division may grant or deny the Application, or make an adjustment modifying the provider's proposal. If the materials filed by the provider are inadequate to serve as a basis for a reasonable decision, the Division shall deny the Application, unless additional proofs are submitted.

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(g) For adjustments requiring prior approval of the Division, such approval should be sought before the provider makes any commitment to expenditures. An Application for Prior Approval is subject to the same requirements as an Application for a Rate Adjustment under this section.

(h) Rate adjustments made under this section may be continued as such, at the discretion of the Division, notwithstanding a general rebase of costs. Costs which are the basis for a continuing rate adjustment shall not be included in the cost categories used as the basis for the other rate components.

(i) The Division may require an applicant for a rate adjustment under this section or under subsection 4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of subsection 5.9 Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 4.11, the Division may take into account the effect of such changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

8.8 Limitation on Availability of Rate Adjustments

Providers may not apply for a rate adjustment under this section for the sole reason that actual costs incurred by the facility exceed the rate of payment.

9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

The Medicaid per diem payment rate for nursing home services are calculated according to this section as follows:

9.1 Nursing Facility Rate Components

The per diem rate of reimbursement consists of the following rate components:

(a) Nursing Care
(b) Resident Care
(c) Indirect
(d) Director of Nursing
(e) Property and Related
(f) Ancillaries
(g) Adjustments (if any)

9.2 Calculation of the Total Rate

The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for the components listed in Subsection 9.1, adjusted in accordance with the Inflation Factors, as described in Subsection 5.8.

9.3 Updating Rates for a Change in the Average Case-Mix Score

(a) The Nursing Care rate component shall be updated quarterly, on the first day of January, April, July and October, for changes in the average case-mix score of the facility's Medicaid residents.

(b) The Nursing Care rate component and any part of a Section 8 adjustment that reimburses nursing costs are updated for a change in the average case-mix score for the facility's Medicaid residents. The up-date is calculated as follows:

(1) The Nursing Care rate component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case-mix score used to determine the current Nursing Care rate component. This quotient is the current Nursing Care rate per case-mix point.

(2) The current Nursing Care rate component (or rate adjustment) per case-mix point is multiplied by the new average case-mix score. This product is the new Nursing Care rate component (or rate adjustment).

9.4 State Nursing Facilities

State nursing facilities shall be subject to the provisions of these rules, except for the rate limitations in Section 7 and subsection 9.1(g).

However, at no time shall the rates paid to State nursing facilities exceed the upper limits established in 42 C.F.R. §447.272(b).

10 EXTRAORDINARY FINANCIAL RELIEF

10.1 Objective

In order to protect Medicaid recipients from the closing of a nursing facility in which they reside, this section establishes a process by which nursing homes that are in immediate danger of failure may seek extraordinary financial relief. This process does not create any entitlement to rates in excess of those required by 33 V.S.A. Chapter 9 or to any other form of relief.

10.2 Nature of the Relief

(a) Based on the individual circumstances of each case, the Director may recommend any of the following on such conditions as she or he shall find appropriate: a rate adjustment, an advance of Medicaid payments, other relief appropriate to the circumstances of the applicant, or no relief.

(b) The Director's Recommendation shall be in writing and shall state the reasons for the Recommendation. The Recommendation shall be a public record.

(c) The Recommendation shall be reviewed by the Secretary who shall make a Final Decision, which shall not be subject to administrative or judicial review.

10.3 Criteria to be Considered by the Division

(a) Before a provider may apply for extraordinary financial relief, its financial condition must be such that there is a substantial likelihood that it will be unable to continue in existence in the immediate future.

(b) The following factors will be considered by the Director in making the Recommendation to the Secretary:

(1) the likelihood of the facility's closing without financial assistance,

(2) the inability of the applicant to pay bona fide debts,

(3) the potential availability of funds from related parties, parent corporations, or any other source,

(4) the ability to borrow funds on reasonable terms,

(5) the existence of payments or transfers for less than adequate consideration,

(6) the extent to which the applicant's financial distress is beyond the applicant's control,

(7) the extent to which the applicant can demonstrate that assistance would prevent, not merely postpone the closing of the facility,

(8) the extent to which the applicant's financial distress has been caused by a related party or organization,

(9) the quality of care provided at the facility,

(10) the continuing need for the facility's beds, and

(11) other factors found by the Director to be material to the particular circumstances of the facility.

10.4 Procedure for Application

(a) An Application for Extraordinary Financial Relief shall be filed with the Division according to procedures to be prescribed by the Director.

(b)The Application shall be in writing and shall be accompanied by such documentation and proofs as the Director may prescribe. The burden of proof is at all times on the provider. If the materials filed by the provider are inadequate to serve as a basis for a reasoned recommendation, the Division shall deny the

Application, unless additional proofs are submitted.

(c) The Secretary shall not be bound in considering other Applications by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility.

11 PAYMENT FOR OUT-OF-STATE PROVIDERS

11.1 Long-Term Care Facilities Other Than Rehabilitation Centers

Payment for services, other than Rehabilitation Center services, provided to Vermont Medicaid residents in long-term care facilities in another state shall be at the per diem rate established for Medicaid payment by the appropriate agency in that state. Payment of the per diem rate shall constitute full and final payment, and no retroactive settlements will be made.

11.2 Rehabilitation Centers

(a) Payment for prior-authorized Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled, such as head injured or ventilator dependent people, will be made at the lowest of:

(1) the amount charged; or

(2) the Medicaid rate, including ancillaries as paid by at least one other state agency in HCFA Region I.

(b) Payment for Rehabilitation Center services which have not been prior authorized by the Director of the Office of Vermont Health Access or a designee will be made according to Subsection 11.1.

11.3 Pediatric Care

No Medicaid payments will be made for services provided to Vermont pediatric residents in out-of-state long-term care facilities with out the prior authorization of the Director of the Office of Vermont Health Access.

12 RATES FOR ICF/MRS

12.1 Reasonable Cost Reimbursement

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement, pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency for the Department of Developmental and Mental Health Services.

12.2 Application of these Rules to ICF/MRS

The Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3) shall apply to this program.

13 RATES FOR SWING BEDS

Payment for swing-bed nursing facility services provided by hospitals, pursuant to 42 U.S.C. §1396l(a), shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. Supplemental payment made pursuant to subsection 14, 17.1 shall not be included in the calculation of swing-bed rates.

14 Special Rates for Difficult to Place Individuals

14.1 Availability of Special Rates

(a) In rare and exceptional circumstances, Vermont nursing facilities may be paid a special rate for the care of an individual eligible for the Vermont Medicaid program whose unique physical conditions makes it otherwise extremely difficult to obtain appropriate long-term care.

(b) A special rate under this section is available at the sole discretion of the Director of the Office of Vermont Health Access subject to the conditions set out below. The

decision of the Director of the Office of Vermont Health Access shall not be subject to judicial or administrative review.

14.2 **Required Findings**

Before a rate is payable under this section:

(a) the Director of the Office of Vermont Health Access, in consultation with the Office's Medical Director, and the Director of Licensing and Protection, must make a written finding that the individual's care needs meet the requirements of this section and that the proposed placement is appropriate for that individual's needs; and

(b) the Division of Rate Setting, in consultation with the Director of the Office of Health Access and the Commissioner of Aging and Disabilities must determine that the special rate set under this section is lower than the lowest cost of an appropriate and available care alternative.

14.3 **Plan of Care**

(a) Before an individual can be placed with any facility and a rate established, pursuant to this subsection, a plan of care for that person must be approved by the Director of Licensing and Protection and the Medical Director of the Office of Vermont Health Access.

(b) The facility shall submit the resident's assessment and plan of care for review by the Director of Licensing and Protection and the Medical Director of the Office of Vermont Health Access whenever there is a significant change in the resident's condition, but in no case less frequently than every six months. This review shall form the basis for a determination that the payment of the special rate should be continued or revised pursuant to 14.4(b).

14.4 Calculation of the Special Rate

(a) A per diem rate shall be set by the Division based on the budgeted allowable incremental costs for the individual's plan of care. The rate shall be exempt from the limits in section 7 of these rules.

(b) From time to time the special rate may be revised to reflect significant changes in the resident's assessment and care plan.

(c) Special rates set under this section shall not affect the facility's normal per diem rate. The case-mix weight of any resident on whose behalf a special rate is paid shall not be included in the calculation of the facility's average case-mix score pursuant to subsection 7.2(b), but the days of care shall be included in the facility's Medicaid days and total resident days.

15 ADMINISTRATIVE REVIEW AND APPEALS

15.1 **Draft Findings and Decisions**

(a) Before issuing findings on any Desk Review, Audit of a Cost Report, statement of deprecation recapture, or decision on any application for a rate adjustment, the Division shall serve a draft of such findings or decision on the affected provider. If the Division makes no adjustment to a facility's reported costs or application for a rate adjustment, the Division's findings shall be final and shall not be subject to appeal under this section.

(b) The provider shall review the draft upon receipt. If it desires to review the Division's work papers, it shall file, within 10 days, a written Request for Work Papers on a form prescribed by the Director.

15.2 **Request for an Informal Conference on Draft Findings and Decisions**

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to Subsection 15.1(a) may file a written Request for an Informal Conference with the Division's staff on a form prescribed by the Director.

(b) Within 10 days of the receipt of the Request, the Division shall contact the provider to arrange a mutually convenient time for the informal conference, which may be held by

telephone. At the conference, if necessary, a date certain shall be fixed by which the provider may file written submissions or other additional necessary information. Within 20 days thereafter, the Division shall issue its official agency action.

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to Subsection 15.3.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in Subsection 15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

15.3 **Request for Reconsideration**

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 15.2(b) may file a Request for Reconsideration.

(b) A Request for Reconsideration must be pursued before an appeal can be taken pursuant to 33 V.S.A. 909(a).

(c) The Request for Reconsideration must be in writing, on a form prescribed by the Director, and filed within 30 days of the provider's receipt of the official action.

(d) Within 10 days of the filing of a Request for Reconsideration, the provider must file the following:

(1) A request for a hearing, if desired;

(2) a clear statement of the alleged errors in the Division's action and of the remedy requested including: a description of the facts on which the Request is based, a memorandum stating the support for the requested relief in this rule, HCFA-15, or other authority for the requested relief and the rationale for the requested remedy; and

(3) if no hearing is requested, evidence necessary to bear the provider's burden of proof, including, if applicable, a proposed revision of the Division's calculations, with supporting work papers.

(e) Issues not raised in the Request for Reconsideration shall not be raised later in this proceeding or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(f) If a hearing is requested, within 10 days of the receipt of the Request for Reconsideration, the Division shall contact the provider to arrange a mutually agreeable time.

(g) The hearing shall be conducted by the Director or her or his designee. The testimony shall be under oath and shall be recorded either stenographically or on tape. If the provider so requests, the Division staff involved in the official action appealed shall appear and testify. The Director, or her or his designee, may hold the record open to a date certain for the receipt of additional materials.

(h) The Director shall issue a Final Order on Request for Reconsideration no later than 30 days after the record closes. Pending the issuance of a final order, the official action issued pursuant to subsection 15.2(b) shall be used as the basis for setting an interim rate from the first day of the calendar quarter following its issuance. Final orders shall be effective from the effective date of the official action, except for appeals of the calculation of depreciation recovery which shall be effective from the date of the sale and which shall accrue interest from that date at the legal rate.

(i) Proceedings under this section are not subject to the requirements of 3 V.S.A. Chapter 25.

15.4 **Appeals from Final Orders of the Division**

(a) Within 30 days of the date thereof, a nursing facility aggrieved by a Final Order of the Division may file an appeal pursuant to 33 V.S.A. §909(a) and Subsections 15.5, 15.6 and 15.7 of this rule.

(b) Within 30 days of the date thereof, a ICF/MR aggrieved by a Final Order of the Division may file an appeal with the Vermont Human Services Board pursuant to §7.12 of the *Regu-*